RECORD AND BRIEFS

Supreme Court, U.S.
FILED
AUG - 4 2016
CLERK

No. 15-797

IN THE

Supreme Court of the United States

BOBBY JAMES MOORE,

Petitioner,

v.

TEXAS,

Respondent.

On Writ of Certiorari to the Court of Criminal Appeals of Texas

BRIEF OF *AMICI CURIAE*, THE AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (AAIDD), AND THE ARC OF THE UNITED STATES, IN SUPPORT OF PETITIONER

JAMES W. ELLIS
Counsel of Record
ANN M. DELPHA
CAROL M. SUZUKI
STEVEN K. HOMER
DAVID J. STOUT
APRIL LAND
1117 Stanford, N.E.
Albuquerque, NM 87131
(505) 277-2146
ellis@law.unm.edu

Counsel for Amici Curiae

August 4, 2016

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTEREST OF *AMICI* 1

SUMMARY OF ARGUMENT 3

ARGUMENT 5

I. The Clinical Requirement of Adaptive Deficits 7

A. Stereotypes About People with Intellectual Disability 9

B. The Diagnostic Focus on Deficits 14

C. Co-morbidity with Other Conditions 20

D. Clinical Judgment 24

II. States Are Not Free to Ignore Accepted Scientific Standards in Adjudicating Cases Involving Intellectual Disability 27

CONCLUSION 33

TABLE OF AUTHORITIES

Federal Cases

Atkins v. Virginia, 536 U.S. 304 (2002) ..... *passim*

Brumfield v. Cain, 135 S. Ct. 2269 (2015) 18, 22

City of Cleburne v. Cleburne Living Center, 473 U.S. 432 (1985) 1

Graham v. Florida, 560 U.S. 48 (2010) 27

Hall v. Florida, 134 S. Ct. 1986 (2014) ..... *passim*

Miller v. Alabama, 132 S. Ct. 2455 (2012) 27

Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999) 22

Roper v. Simmons, 543 U.S. 551 (2005) 33

Skipper v. South Carolina, 476 U.S. 1 (1986) 16

State Cases

Ex parte Briseno, 135 S.W.3d 1 (Tex. Crim. App. 2004) 28, 29, 31

Ex parte Cathey, 451 S.W.3d 1 (Tex. Crim. App. 2014) 16, 17, 30

Ex parte Moore, 470 S.W.3d 481 (Tex. Crim. App. 2015) 16, 17, 29

Ex parte Sosa, 364 S.W.3d 889 (Tex. Crim. App. 2012) 30, 31

Statutes

Act of May 22, 1929, No. 281, § 1, 1929 Mich. Pub. Acts 689 11

Tex. Health & Safety Code Ann. § 593.005 (West 2010 & Supp. 2016) 30

Rules

Fed. R. Evid. 403 31

Other Authorities

American Association on Intellectual and Developmental Disabilities, *Intellectual Disability: Definition, Classification, and Systems of Supports* (11th ed. 2010) ..... *passim*

American Association on Intellectual and Developmental Disabilities, *User's Guide: Intellectual Disability: Definition, Classification, and Systems of Supports* (2012) 12, 15, 31–32

American Association on Mental Deficiency, *Classification in Mental Retardation* (rev. ed. 1983) 14

American Association on Mental Deficiency, *Manual on Terminology and Classification in Mental Retardation* (rev. ed. 1973) 7, 14, 23

American Association on Mental Deficiency, *A Manual on Terminology and Classification in Mental Retardation* (2d ed. 1961) 14

American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* (10th ed. 2002) 18, 22

American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* (9th ed. 1992) 10–11, 14, 18, 23

American Educational Research Association, American Psychological Association, and National Council on Measurement in Education, *Standards for Educational and Psychological Testing* (2014) 25

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013) ..... *passim*

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. text rev. 2000) 22

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (3d ed. rev. 1987) 14

American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct*, 57 Am. Psychologist 1060 (2002) 26

American Psychological Association, *Manual of Diagnosis and Professional Practice in Mental Retardation* (John W. Jacobson & James A. Mulick eds., 1996) 14

American Psychological Association, *Specialty Guidelines for Forensic Psychology*, 68 Am. Psychologist 7 (2013) 26

Anastasi, Anne & Susana Urbina, *Psychological Testing* (7th ed. 1997) 7

Boccaccini, Marcus T., John W. Clark, Lisa Kan, Beth Caillouet & Ramona M. Noland, *Jury Pool Members' Beliefs About the Relation Between Potential Impairments in Functioning and Mental Retardation: Implications for Atkins-Type Cases*, 34 Law & Psychology Rev. 1 (2010) 12

Charlot, Lauren, Sherm Fox, Van R. Silka, Anne D. Hurley, Michael A. Lowry & Robert Pary, *Mood Disorders*, in *Diagnostic Manual–Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability* 271 (Robert Fletcher et al. eds., 2007)..... 21

Dosen, Anton & Jan J. M. Gielen, *Depression in Persons with Mental Retardation: Assessment and Diagnosis*, in *Mental Health Aspects of Mental Retardation: Progress in Assessment and Treatment* 70 (Robert J. Fletcher & Anton Dosen eds., 1993)..... 21

Everington, Caroline, Gilbert S. Macvaugh III, Karen L. Salekin & Timothy J. Derning, *Challenges in the Assessment of Adaptive Behavior of People Who Are Incarcerated*, in *The Death Penalty and Intellectual Disability* 201 (Edward A. Polloway ed., 2015).... 16

Everington, Caroline, *Challenges of Conveying Intellectual Disabilities to Judge and Jury*, 23 Wm. & Mary Bill Rts. J. 467 (2014) 19, 31

Hartley, Sigan L. & William E. MacLean, Jr., *Depression in Adults with Mild Intellectual Disability: Role of Stress, Attributions, and Coping*, 114 Am. J. Intellectual & Developmental Disabilities 147 (2009)..... 21

Kersh, Joanne, *Attitudes About People with Intellectual Disabilities: Current Status and New Directions*, in 41 *International Review of Research in Developmental Disabilities* 199 (Robert M. Hodapp ed., 2011) 12

Lyon, Andrea D., *But He Doesn't* Look *Retarded: Capital Jury Selection for the Mentally Retarded Client Not Excluded After Atkins v. Virginia*, 57 DePaul L. Rev. 701 (2008) 12

Macvaugh, Gilbert S. III & Mark D. Cunningham, *Atkins v. Virginia: Implications and Recommendations for Forensic Practice*, 37 J. Psychiatry & L. 131 (2009) 10, 13, 15, 17, 26, 31

Mank, David, *Employment*, in *Handbook of Developmental Disabilities* 390 (Samuel L. Odom et al. eds., 2007) 13

Nihira, Kazuo, *Adaptive Behavior: A Historical Overview*, in *Adaptive Behavior and Its Measurement: Implications for the Field of Mental Retardation* 7 (Robert L. Schalock ed., 1999) 7

Olley, J. Gregory, *The Death Penalty, the Courts, and Intellectual Disabilities*, in *The Handbook of High-Risk Challenging Behaviors in People with Intellectual and Developmental Disabilities* 229 (James K. Luiselli ed., 2012)..... 11, 19, 20, 22–23

Olley, J. Gregory & Ann W. Cox, *Assessment of Adaptive Behavior in Adult Forensic Cases: The Use of the Adaptive Behavior Assessment System–II*, in *Adaptive Behavior Assessment System–II: Clinical Use and Interpretation* 381 (Thomas Oakland & Patti L. Harrison eds., 2008) 16–17

Reschly, Daniel J., *Documenting the Developmental Origins of Mild Mental Retardation*, 16 Applied Neuropsychology 124 (2009) 9, 12–13

Ryan, Ruth, *Posttraumatic Stress Disorder in Persons with Developmental Disabilities*, 30 Community Mental Health J. 45 (1994)..... 22

Schalock, Robert L. & Ruth Luckasson, *Clinical Judgment* (2d ed. 2014)..... 14, 25, 26

Siperstein, Gary N. & Melissa A. Collins, *Intellectual Disability*, in *The Death Penalty and Intellectual Disability* 21 (Edward A. Polloway ed., 2015)..... 13

Snell, Martha E. & Ruth Luckasson, with Sharon Borthwick-Duffy, Val Bradley, Will H. E. Buntinx, David L. Coulter, Ellis (Pat) M. Craig, Sharon C. Gomez, Yves Lachapelle, Alya Reeve, Robert L. Schalock, Karrie A. Shogren, Scott Spreat, Marc J. Tassé, James R. Thompson, Miguel A. Verdugo, Michael A. Wehmeyer & Mark H. Yeager, *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs*, 47 Intellectual & Developmental Disabilities 220 (2009) 10, 11, 13, 18

Stancliffe, Roger J. & K. Charlie Lakin, *Independent Living*, in *Handbook of Developmental Disabilities* 429 (Samuel L. Odom et al. eds., 2007) 13

Stavrakaki, Chrissoula & Yona Lunsky, *Depression, Anxiety, and Adjustment Disorders in People with Intellectual Disabilities*, in *Psychiatric and Behavioural Disorders in Intellectual and Developmental Disabilities* 113 (Nick Bouras & Geraldine Holt eds., 2d ed. 2007) 22

Szymanski, Ludwik S. & Maija Wilska, *Childhood Disorders: Mental Retardation*, in 1 *Psychiatry* 687 (Allan Tasman et al. eds., 2d ed. 2003) 22

Tassé, Marc J., *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114 (2009) 10, 16, 25

Tomasulo, Daniel J. & Nancy J. Razza, *Posttraumatic Stress Disorder*, in *Diagnostic Manual–Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability* 365 (Robert Fletcher et al. eds., 2007) 21

Trent, James W., Jr., *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (1994) 11

Wehmeyer, Michael L. & Susan B. Palmer, *Adult Outcomes for Students with Cognitive Disabilities Three-Years After High School: The Impact of Self-Determination*, 38 Education & Training in Developmental Disabilities 131 (2003) 13–14

Widaman, Keith F., *Concepts of Measurement*, in *The Death Penalty and Intellectual Disability* 55, (Edward A. Polloway ed., 2015) 25

Widaman, Keith F. & Kevin S. McGrew, *The Structure of Adaptive Behavior*, in American Psychological Association, *Manual of Diagnosis and Professional Practice in Mental Retardation* 97 (John W. Jacobson & James A. Mulick eds., 1996) 8

INTEREST OF *AMICI*[1]

Amici are scientific, clinical, and voluntary organizations in the field of intellectual disability.

THE AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES ("AAIDD") (formerly named the American Association on Mental Retardation), founded in 1876, is the nation's oldest and largest organization of professionals in the field of intellectual disability. Through its professional journals, conferences, and book publishing, AAIDD works diligently to advance scientific understanding of intellectual disability. Primarily focused on clinical, psychological, scientific, educational, and habilitative issues, the Association also has a longstanding interest in legal issues that affect the lives of people with intellectual disability. AAIDD has appeared as *amicus curiae* in this Court in a variety of cases involving mental disability, including cases as diverse as *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432 (1985), and *Atkins v. Virginia*, 536 U.S. 304 (2002). AAIDD has

---

[1] This brief was written entirely by counsel for *amici*, as listed on the cover. No counsel for either party authored this brief in whole or in part, and neither counsel for a party nor any party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than the members of the organizational *amici* or their counsel made a monetary contribution to the preparation or submission of this brief. All parties have filed notices of consent to the filing of *amicus curiae* briefs in support of either party, or neither party, with the Clerk's Office.

formulated the most widely accepted clinical definition of intellectual disability. Both as the formulator of the clinical definition of intellectual disability, and as an interdisciplinary membership organization concerned with maintaining appropriate professional standards in the diagnosis of intellectual disability, AAIDD and its members have a strong interest in the manner in which *Atkins* claims are evaluated by courts.

THE ARC OF THE UNITED STATES ("The Arc"), founded in 1950, is the nation's largest community-based organization of and for people with intellectual and developmental disabilities and consists of nearly 700 state and local chapters across the country. The Arc promotes and protects the human and civil rights of people with intellectual and developmental disabilities and actively supports their full inclusion and participation in the community throughout their lifetimes. Through its National Center on Criminal Justice and Disability, The Arc serves as a national clearinghouse for information, training, and advocacy on the topic of people with intellectual and developmental disabilities involved in the criminal justice system. The Arc has a vital interest in ensuring that all individuals with intellectual and developmental disabilities receive the protections and supports to which they are entitled by law, and that courts and administrative agencies employ commonly accepted scientific principles for the diagnosis of intellectual and developmental disabilities. The Arc has appeared as *amicus curiae* in this Court in a variety of cases involving intellectual and developmental

disabilities, including *Atkins v. Virginia*, 536 U.S. 304 (2002), and *Hall v. Florida*, 134 S. Ct. 1986 (2014).

SUMMARY OF ARGUMENT

As with any field of scientific inquiry, our understanding of the condition of intellectual disability is improved and enhanced over time by continuing, rigorous study and analysis. The scientific study and the diagnosis of intellectual disability involve issues important to scholars and clinicians. But *amici* believe that there is no need for this Court to become enmeshed in the details and intricacies of those scholarly efforts in order to resolve the instant case and to provide guidance to lower courts in their task of fairly adjudicating cases under *Atkins v. Virginia*, 536 U.S. 304 (2002). This Court need only affirm that States must conform to the basic framework of the *clinical* definition of intellectual disability.

The clinical definition of intellectual disability consists of three prongs.[2] The first prong requires impairment in intellectual functioning. This Court made clear in *Hall v. Florida*, 134 S. Ct. 1986 (2014), that States cannot artificially ration the number of *Atkins*-eligible capital defendants by arbitrarily rejecting universally accepted scientific principles in evaluating test scores.

---

[2] The third prong of the definition, regarding the age of onset, is not at issue in this case.

The second prong requires deficits in adaptive behavior. As the Court observed in *Hall*, "Intellectual disability is a condition, not a number." 134 S. Ct. at 2001. Although the precise clinical terminology has evolved over time, the core principles about the interpretation of adaptive deficits have been well settled among clinicians for decades. Central to this clinical consensus is agreement that the inquiry must focus on *deficits* in adaptive skills, and not some form of "balancing" those deficits with supposed strengths that an individual might appear to possess. Equally well accepted is the fact that many individuals with intellectual disability may also have other conditions or disabilities (known as "co-morbidity" or "dual diagnosis") and those other conditions do not affect the diagnosis of intellectual disability.

Texas has distorted the clinical definition's carefully crafted and scientifically tested requirements for the second prong. It has devised a formula of exclusionary "factors," a formula that rests heavily on stereotypes about people with intellectual disability. This approach is wholly inconsistent with accepted scientific standards. Deviating from the basic clinical framework of the definition inevitably leads to inaccurate and unreliable results, and protects only a sub-set of defendants with intellectual disability.

This deliberate decision to reject clinical standards in the adjudication of death penalty cases is inconsistent with this Court's holdings, and incompatible with the Eighth Amendment.

ARGUMENT

In *Atkins v. Virginia*, 536 U.S. 304 (2002), this Court held that the Cruel and Unusual Punishments Clause of the Eighth Amendment forbids the execution of any individuals who fall within the clinical definition of intellectual disability (or, previously, "mental retardation").[3] "Because of their impairments, . . . by definition they have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others." 536 U.S. at 318.[4]

The clinical definition of intellectual disability consists of three requirements: reduced intellectual functioning (as measured by IQ testing), deficits in adaptive skills, and onset of the disability before adulthood.[5] In *Hall v. Florida*, this Court addressed

---

[3] This Court has noted the change in terminology from "mental retardation" to "intellectual disability." *Hall v. Florida*, 134 S. Ct. 1986, 1990 (2014).

[4] *See also Hall*, 134 S. Ct. at 1992 ("No legitimate penological purpose is served by executing a person with intellectual disability. To do so contravenes the Eighth Amendment, for to impose the harshest of punishments on an intellectually disabled person violates his or her inherent dignity . . . ." (citation omitted)).

[5] American Association on Intellectual and Developmental Disabilities (AAIDD), *Intellectual Disability: Definition, Classification, and Systems of Supports* 5 (11th ed. 2010) [hereinafter AAIDD, *Manual 2010*] ("Intellectual disability is characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed

the implementation of the definition's first prong—the requirement of significant limitations in intellectual functioning—and noted that the clinical definition of intellectual disability is "a fundamental premise of *Atkins*." 134 S. Ct. 1986, 1999 (2014).[6]

This case involves the second prong of the definition: the diagnostic requirement that an individual have "significant limitations . . . in adaptive behavior."[7]

---

in conceptual, social, and practical adaptive skills. This disability originates before age 18."); *see also* American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 33 (5th ed. 2013) [hereinafter *DSM-5*] ("Intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.").

[6] In the present case, the expert testimony makes clear that Petitioner satisfies the first prong of the definition, Joint Appendix at 17, 39, 73, 89, and the judge who heard the testimony so found. Petitioner's Appendix at 167a.

[7] AAIDD, *Manual 2010*, *supra* note 5, at 5. Over the years, the precise language used by professionals in the field to describe the adaptive behavior (sometimes abbreviated as AB) prong has varied somewhat, reflecting advances in clinical understanding and practices. But these changes in terminology have not affected the concept of adaptive behavior or altered the category of individuals who are found to have significant deficits. *See id.* at 11 ("[B]oth the definition of ID [intellectual disability] and its operationalization have remained consistent over time."). State statutes also vary somewhat in their terminology regarding adaptive behavior, having been adopted at different times and incorporating language derived from different iterations of the definition. All of these statutory definitions are grounded in clinical understanding, and encompass the same set of individuals.

There is a substantial, consistent, and robust body of clinical and scientific literature on the meaning and application of this requirement. Accurate and valid diagnoses must be informed by that clinical understanding.

I. The Clinical Requirement of Adaptive Deficits.

For decades, the clinical definition of intellectual disability has required a determination that the individual has, in addition to limitations in intellectual functioning, deficits in adaptive functioning.[8] This requirement reflects the consensus among clinicians and professional organizations in the field that "intellectual limitation is a necessary but not a sufficient condition for mental retardation." Anne Anastasi & Susana Urbina, *Psychological Testing* 248 (7th ed. 1997). The purpose of this component of the definition is to exclude from the diagnosis any individual whose low scores on IQ testing is not accompanied by a substantially disabling impairment of functioning in

---

[8] *See, e.g.*, American Association on Mental Deficiency, *Manual on Terminology and Classification in Mental Retardation* 11 (rev. ed. 1973) ("Mental Retardation refers to significantly subaverage general intellectual functioning *existing concurrently with deficits in adaptive behavior*, and manifested during the developmental period." (emphasis added)). For a discussion on the evolution of the adaptive behavior component, see Kazuo Nihira, *Adaptive Behavior: A Historical Overview*, in *Adaptive Behavior and Its Measurement: Implications for the Field of Mental Retardation* 7, 7–14 (Robert L. Schalock ed., 1999).

life.[9] Put another way, the adaptive behavior requirement is designed to restrict the diagnosis of intellectual disability to those individuals who, in addition to their low IQ scores, also have an actual, significant disability that affects their lives and reduces their ability to function in society. *See Hall*, 134 S. Ct. at 1999 (These individuals have "diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in

---

[9] *See generally* AAIDD, *Manual 2010*, *supra* note 5, at 43 ("Adaptive behavior is the collection of conceptual, social, and practical skills that have been learned and are performed by people in their everyday lives."). The American Psychiatric Association's classification manual similarly requires:

> [d]eficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

DSM-5, *supra* note 5, at 33. The American Psychological Association recognizes the same diagnostic requirement. *See* Keith F. Widaman & Kevin S. McGrew, *The Structure of Adaptive Behavior*, in American Psychological Association, *Manual of Diagnosis and Professional Practice in Mental Retardation* 97, 97 (John W. Jacobson & James A. Mulick eds., 1996) ("To be identified as having [mental retardation], a person must exhibit both significantly subaverage intelligence and deficits in adaptive behavior during the developmental period."); *id.* ("Adaptive behaviors are the behavioral skills that people typically exhibit when dealing with the environmental demands they confront.").

logical reasoning, to control impulses, and to understand the reactions of others." (quoting *Atkins*, 536 U.S. at 318)). Thus, it excludes from the diagnosis of ID people who are merely poor test-takers.[10]

Decades of scientific study and clinical experience have produced a remarkable consensus on several key issues relating to the proper diagnosis of the second prong of the definition.

A. Stereotypes About People with Intellectual Disability

There is a wide gap between the clinical definition, on the one hand, and on the other, expectations that many laypeople have about what intellectual disability (or mental retardation) means. Common mis-impressions include beliefs that people with ID are essentially identical to one another, and that all are incapable of any but the most rudimentary tasks. The magnitude of that gap and its consequences can be particularly problematic. As a prominent leader in the field of intellectual disability has observed:

---

[10] *See* Daniel J. Reschly, *Documenting the Developmental Origins of Mild Mental Retardation*, 16 Applied Neuropsychology 124, 132 (2009) ("Even a very low score on a single measure of general intellectual functioning is never sufficient.").

> Most individuals with mental retardation will have strengths and areas of ability. These strengths may confound a layperson or a professional with limited clinical experience with individuals who have mild mental retardation. These laypersons may erroneously interpret these pockets of strengths and skills as inconsistent with mental retardation because of their misconceptions regarding what someone with mental retardation can or cannot do.

Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 121 (2009) (citation omitted).[11]

---

[11] Several authorities cited in this brief occasionally use the term "mild" intellectual disability or mental retardation as part of a mild/moderate/severe/profound taxonomy. The term "mild" encompasses roughly 85–90% of people who are within the clinical definition of ID, but almost certainly a much higher proportion of *Atkins* cases. Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 117 (2009); Gilbert S. Macvaugh III & Mark D. Cunningham, *Atkins v. Virginia: Implications and Recommendations for Forensic Practice*, 37 J. Psychiatry & L. 131, 142 (2009) ("virtually all" *Atkins* cases). *See generally* Martha E. Snell & Ruth Luckasson et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs*, 47 Intellectual & Developmental Disabilities 220, 228 (2009). A principal reason why many clinicians no longer use these diagnostic subcategories is because the term "mild," a euphemism, can be mistakenly read to suggest that such people have only minimal impairments, and thus the term understates the extent of their deficits. *See* American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports*

Such preconceived assumptions about what it means for someone to have intellectual disability often contrast sharply with the understanding of professionals and clinicians in the field.[12] Some of these stereotyped notions are triggered by an individual's physical appearance,[13] but many are also

---

34 (9th ed. 1992). In reality, everyone within that category faces the same functional issues addressed by the Court in *Atkins* and *Hall*. *Atkins v. Virginia*, 536 U.S. 304, 320 (2002); *Hall v. Florida*, 134 S. Ct. 1986, 1993 (2014).

12 People with intellectual disability have been confronted by popular misunderstandings and stereotypes throughout history. *See* James W. Trent, Jr., *Inventing the Feeble Mind: A History of Mental Retardation in the United States* 131–224 (1994). In the past, many of these stereotypes gave rise to egregious legislation, particularly at the state level. For example, a 1929 Michigan statute provided, "It is hereby declared to be the policy of the state to prevent the procreation and increase in number of feeble-minded, insane and epileptic persons, idiots, imbeciles, moral degenerates, and sexual perverts, likely to become a menace to society or wards of the state. The provisions of this act are to be liberally construed to accomplish this purpose." Act of May 22, 1929, No. 281, § 1, 1929 Mich. Pub. Acts 689, 689–90.

13 *See* J. Gregory Olley, *The Death Penalty, the Courts, and Intellectual Disabilities*, in *The Handbook of High-Risk Challenging Behaviors in People with Intellectual and Developmental Disabilities* 229, 231 (James K. Luiselli ed., 2012) ("[T]he public generally misunderstands mild ID and expects that such individuals are easy to identify by their physical appearance, their speech, or other readily apparent characteristics."); Martha E. Snell & Ruth Luckasson et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs*, 47 Intellectual & Developmental Disabilities 220, 220 (2009) ("Most of these individuals [in the range of mild intellectual disability] are physically indistinguishable from the general population because no specific physical features are associated with intellectual

based on the public's often uninformed expectations about what people with intellectual disability supposedly cannot do. There is a strong impulse to conjure up our own image of what people with intellectual disability are like, and then to evaluate individuals by how closely they seem to resemble that preconceived image of "a mentally retarded person."[14]

---

disability at higher [IQ levels]."); American Association on Intellectual and Developmental Disabilities, *User's Guide: Intellectual Disability: Definition, Classification, and Systems of Supports* 25–26 (2012) ("Physical appearance can also contribute to stereotypes as reflected in the statement that 'if you don't have the look (as in Down syndrome) then you are not intellectually disabled.' It should be noted that the vast majority of persons with an ID have no dysmorphic feature and generally walk and talk like persons without an ID.").

[14] *See, e.g.*, Joanne Kersh, *Attitudes About People with Intellectual Disabilities: Current Status and New Directions*, in 41 *International Review of Research in Developmental Disabilities* 199, 220 (Robert M. Hodapp ed., 2011) ("Additionally, a lack of familiarity with people with ID may lead to a reliance on common misperceptions and stereotypes in order to make judgments and decisions about individuals."); Marcus T. Boccaccini et al., *Jury Pool Members' Beliefs About the Relation Between Potential Impairments in Functioning and Mental Retardation: Implications for Atkins-Type Cases*, 34 Law & Psychol. Rev. 1, 18 (2010); Andrea D. Lyon, *But He Doesn't* Look *Retarded: Capital Jury Selection for the Mentally Retarded Client Not Excluded After Atkins v. Virginia*, 57 DePaul L. Rev. 701, 712 (2008) ("Many mistakenly believe that one can merely *look* at a person and tell whether he is mentally retarded.").

Stereotypes about intellectual disability are often based on images of people with more severe or profound levels of impairment than those individuals who are most frequently encountered in capital cases. *See* Daniel J. Reschly,

These lay assumptions sometimes include an imagined "list" of things that people with intellectual disability cannot do. The activities that are supposedly inconsistent with intellectual disability can involve, for example, employment, social relationships, reading and writing, and driving a car. But the clinical literature is abundantly clear that many of the people who have been properly diagnosed with intellectual disability can perform one or more of these tasks.[15]

Documenting the Developmental Origins of Mild Mental Retardation, 16 Applied Neuropsychology 124, 125 (2009) ("Death penalty appeals involving claims of MR . . . virtually always involve [mild mental retardation]."); Macvaugh & Cunningham, *supra* note 11, at 142 ("[V]irtually all [capital offenders with mental retardation] are within the mild category of mental retardation.") (The Macvaugh and Cunningham article is an outgrowth of the ad hoc committee on *Atkins* evaluations within the section of the American Psychological Association concerned with intellectual disability.).

[15] *See, e.g.*, Daniel J. Reschly, *Documenting the Developmental Origins of Mild Mental Retardation*, 16 Applied Neuropsychology 124, 133 (2009); Martha E. Snell & Ruth Luckasson et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs*, 47 Intellectual & Developmental Disabilities 220, 220–21 (2009); Roger J. Stancliffe & K. Charlie Lakin, *Independent Living*, in *Handbook of Developmental Disabilities* 429, 430 (Samuel L. Odom et al. eds., 2007) ("Seminal studies have documented the ability of many people with ID to live reasonably successfully in the community with relatively modest formal support . . . ." (citations omitted)); Gary N. Siperstein & Melissa A. Collins, *Intellectual Disability*, in *The Death Penalty and Intellectual Disability* 21, 26–29 (Edward A. Polloway ed., 2015); David Mank, *Employment*, in *Handbook of Developmental Disabilities* 390, 392 (Samuel L. Odom et al. eds., 2007); Michael L. Wehmeyer & Susan B. Palmer, *Adult Outcomes for Students with Cognitive Disabilities Three-Years After High School: The*

The scholarly literature provides no support for any such exclusionary list of everyday tasks incompatible with a diagnosis of intellectual disability. Nor is there such a list in the experience of clinicians who deal with individuals with intellectual disability every day.

B. The Diagnostic Focus on Deficits

The clinical definition of adaptive behavior has long focused exclusively on adaptive *deficits*.[16] As a

---

Impact of Self-Determination, 38 Education & Training in Developmental Disabilities 131, 139–40 (2003); *see also* Robert L. Schalock & Ruth Luckasson, *Clinical Judgment* 38–39 (2d ed. 2014).

[16] *See, e.g.*, AAIDD, *Manual 2010*, *supra* note 5, at 1 ("significant *limitations* . . . in adaptive behavior"); *DSM-5*, *supra* note 5, at 33 ("*[d]eficits* in adaptive functioning"); American Psychological Association, *Manual of Diagnosis and Professional Practice in Mental Retardation* 13 (John W. Jacobson & James A. Mulick eds., 1996) ("[s]ignificant *limitations* in adaptive functioning"); American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 5 (9th ed. 1992) ("*limitations* in adaptive skills"); American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 32 (3d ed. rev. 1987) ("[c]oncurrent *deficits or impairments* in adaptive functioning"); American Association on Mental Deficiency [now AAIDD], *Classification in Mental Retardation* 11 (rev. ed. 1983) ("*deficits* in adaptive behavior"); American Association on Mental Deficiency, *Manual on Terminology and Classification in Mental Retardation* 11 (rev. ed. 1973) ("existing concurrently with *deficits* in adaptive behavior"); American Association on Mental Deficiency, *A Manual on Terminology and Classification in Mental Retardation* 3 (2d ed. 1961) ("*[i]mpairment* in adaptive behavior") (emphasis added in each quotation).

result, each diagnostic evaluation explores and documents those things that an individual *cannot* do in everyday life.[17] In the absence of such practical

---

[17] Clinicians have developed sophisticated and detailed methods for objectively answering the question of what deficits or limitations an examined individual may have. These methods include, but are not limited to, psychometric instruments known as adaptive behavior scales. *See* AAIDD, *Manual 2010*, *supra* note 5, at 47 ("Obtaining information from multiple respondents and other relevant sources (e.g., school records, employment history, previous evaluations) is essential to providing corroborating information that provides a comprehensive picture of the individual's functioning."); American Association on Intellectual and Developmental Disabilities, *User's Guide: Intellectual Disability: Definition, Classification, and Systems of Supports* 18 (2012) ("The use of multiple respondents, consistent with this standard, will ensure greater reliability of the information obtained, and provide a broader coverage of adaptive behavior across settings."); *DSM-5*, *supra* note 5, at 37. *See generally Hall v. Florida*, 134 S. Ct. 1986, 1994 (2014) (Evidence of AB deficits include "medical histories, behavioral records, school tests and reports, and testimony regarding past behavior and family circumstances.").

It is worth noting that the diagnostic assessment of deficits in adaptive functioning focuses on typical, everyday functioning, and not on potential or maximum performance. For clinicians, this is very different from the assessment of intellectual functioning (Prong 1), which assesses maximum performance. *See, e.g.*, AAIDD, *Manual 2010*, *supra* note 5, at 47 ("This is a critical distinction between the assessment of adaptive behavior and the assessment of intellectual functioning, where best or maximal performance is assessed."); Macvaugh & Cunningham, *supra* note 11, at 162 (There is a consensus among clinicians that "assessment of adaptive behavior should measure a person's typical or actual *performance*, as opposed to *knowledge* of a skill or estimated potential." (citations omitted)).

The evaluation of "everyday functioning" raises particular issues in prisons. Clinicians agree that prison behavior is not a valid measure of an individual's real-life functioning. While evidence of an inmate's successful adaptation to prison conditions *can* be probative evidence on the separate and distinct issue of future dangerousness, and therefore admissible in mitigation at capital sentencing, *see Skipper v. South Carolina*, 476 U.S. 1, 7 (1986), it is not relevant to an *Atkins* case on the issue of whether the defendant had deficits in adaptive behavior at the time of the offense. Caroline Everington et al., *Challenges in the Assessment of Adaptive Behavior of People Who Are Incarcerated*, in *The Death Penalty and Intellectual Disability* 201, 202 (Edward A. Polloway ed., 2015) ("[A] satisfactory assessment of AB [adaptive behavior] is not possible in a prison context because the individual has no opportunities to demonstrate the presence or absence of adaptive skills typical in day-to-day life. Inmates do not cook, choose clothing, or make independent choices about their day-to-day existence. By design, correctional settings remove virtually all personal control from the individual, and, as such, practical behaviors pertinent to the diagnosis cannot be demonstrated."); *DSM-5*, *supra* note 5, at 38 ("Adaptive functioning may be difficult to assess in a controlled setting (e.g., prisons, detention centers) . . . ."); Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 119 (2009) ("The prison setting is an artificial environment that offers limited opportunities for many activities and behaviors defining adaptive behavior."). In the case at bar, the Court of Criminal Appeals clearly mandated consideration of a defendant's "conduct in a prison society." *Ex parte Moore*, 470 S.W.3d 481, 489 (Tex. Crim. App. 2015). *See Ex parte Cathey*, 451 S.W.3d 1, 26–27 (Tex. Crim. App. 2014).

Another difficulty that arises from an assessment of prison behavior occurs when evidence is admitted in the form of testimony by guards and other correctional officers. *See, e.g.*, J. Gregory Olley & Ann W. Cox, *Assessment of Adaptive Behavior in Adult Forensic Cases: The Use of the Adaptive Behavior Assessment System-II*, in *Adaptive Behavior Assessment System-II: Clinical Use and Interpretation* 381, 386 (Thomas Oakland &

deficits, clinicians cannot diagnose the individual as having intellectual disability. The clinician's diagnostic focus does not — and cannot — involve any form of "balancing" deficits against the abilities or strengths which the particular individual may also possess.[18]

Framing the adaptive behavior prong solely in terms of a person's limitations was not an arbitrary choice in the formulation of the definition of intellectual disability. The diagnostician's singular focus on adaptive deficits (in contrast to balancing strengths and weaknesses) might initially seem counterintuitive to many laypeople. However, this focus on deficits makes clinical sense in the diagnostic process because the second prong's function is to ascertain whether the measured

---

Patti L. Harrison eds., 2008) ("[R]eports from corrections officers or other observations of current functioning in prison are not valid indicators of level of adaptive behavior."); Macvaugh & Cunningham, *supra* note 11, at 161 ("[A]n assessment of a particular inmate's adaptive behavior while in a highly-structured prison environment has very limited correspondence to the adaptive demands of the open community, whether or not the offender's adaptation is compared with other inmates."). And the problems that have been noted, *supra* Section I.A., concerning stereotypes about people with intellectual disability often arise when correctional officers describe observed behavior as either consistent or inconsistent with their own image of the functioning of a person with intellectual disability.

[18] In sharp contrast to the medical community's "diagnostic framework," *Hall*, 134 S. Ct. at 2000, the Court of Criminal Appeals instructs lower courts to consider both strengths and weaknesses. *Moore*, 470 S.W.3d at 489. *See Cathey*, 451 S.W.3d at 27.

intellectual limitations (i.e., the first prong) are accompanied by real-world limitations in the individual's life.[19]

This focus on adaptive deficits is essential to the diagnostic process because clinicians universally recognize that, in the lives of individuals with intellectual disability, weaknesses in functioning almost always co-exist with relative strengths. As the AAIDD classification manual explains, the finding of "significant limitations in conceptual, social, or practical adaptive skills is not outweighed by the potential strengths in some adaptive skills."[20]

---

[19] *See Hall*, 134 S. Ct. at 2001 ("Intellectual disability is a *condition*, not a number." (emphasis added)).

[20] AAIDD, *Manual 2010*, *supra* note 5, at 47. This fact has long been recognized and accepted by clinicians. *See, e.g.*, American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 5 (9th ed. 1992) ("Specific adaptive limitations often coexist with strengths in other adaptive skills or other personal capabilities . . . ."); *see also* Martha E. Snell & Ruth Luckasson et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs*, 47 Intellectual & Developmental Disabilities 220, 220 (2009) ("[A]ll individuals with intellectual disability typically demonstrate strengths in functioning along with relative limitations.").

This Court has recognized this key aspect of the definition of intellectual disability. *See Brumfield v. Cain*, 135 S. Ct. 2269, 2281 (2015) ("[I]ntellectually disabled persons may have 'strengths in social or physical capabilities, strengths in some adaptive skill areas, or strengths in one aspect of an adaptive skill in which they otherwise show an overall limitation.'" (quoting American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 8 (10th ed. 2002))).

Clinical diagnostic standards focus exclusively on *deficits* in adaptive functioning because practically every individual who has intellectual disability also has things that he or she has learned to do, and can do.[21] As a result, the existence of one or more adaptive strengths cannot negate a diagnosis of intellectual disability.[22] The particular functional impairments and adaptive deficits that are experienced by individuals with intellectual disability are not uniform across the class, and the

---

[21] *See, e.g.*, Caroline Everington, *Challenges of Conveying Intellectual Disabilities to Judge and Jury*, 23 Wm. & Mary Bill Rts. J. 467, 471 (2014) ("Interpretation of these findings requires an understanding of typical behavioral expectations of individuals who function in the mild range of ID. For example, the presence of a defendant's strengths in some areas, such as having a history of steady employment or possessing academic skills in the fourth to sixth grade range, is to be expected and does not preclude a diagnosis of ID.").

[22] While it is often important for clinicians to identify and assess a person's strengths and skills for purposes of planning and implementing future individualized educational and habilitative programs, those strengths play no role in the *diagnostic* determination of whether the person meets the definition of intellectual disability. J. Gregory Olley, *The Death Penalty, the Courts, and Intellectual Disabilities*, in *The Handbook of High-Risk Challenging Behaviors in People with Intellectual and Developmental Disabilities* 229, 233 (James K. Luiselli ed., 2012) ("[I]t is important to note that a clinical evaluation emphasizes strengths in order to plan services that capitalize upon those strengths to promote success. An evaluation for the court is focused on deficits because its purpose is to determine a diagnosis, and an ID is, by definition, a condition characterized by deficits.").

diagnostic standards cannot, and do not, require such uniformity.[23]

This diversity among people who have intellectual disability is often unknown to laypeople with limited experience with the disability. However, it is fully documented and well known to clinicians in the field[24] and thus must form the backdrop for any legitimate diagnostic process.

C. Co-morbidity with Other Conditions

Many individuals who have intellectual disability also have other mental or physical disabilities. Co-existing conditions (sometimes referred to as "co-morbid" or "dual diagnosis") can arise in the evaluation process in some *Atkins* cases. This phenomenon has long been recognized by clinicians and mental health professionals.[25]

---

23 *See id.* ("[P]eople with mild ID are a heterogeneous group with individual profiles of relative strengths and weaknesses. One cannot argue that the presence of a particular strength rules out ID, particularly if it is a strength shared with others with ID.").

24 *See, e.g.*, AAIDD, *Manual 2010*, *supra* note 5, at 7 ("[P]eople with ID are complex human beings who likely have certain gifts as well as limitations.").

25 Under the heading of "Comorbidity," the American Psychiatric Association includes several forms of mental illness frequently encountered in individuals who have intellectual disability.

> The most common co-occurring mental and neurodevelopmental disorders are attention-deficit/hyperactivity disorder; depressive and bipolar disorders; anxiety disorders; autism spectrum disorder; stereotypic movement disorder (with or without self-injurious behavior); impulse-control disorders; and major neurocognitive disorder. Major depressive disorder may occur throughout the range of severity of intellectual disability.

DSM-5, *supra* note 5, at 40. The clinical literature about co-morbid depression in individuals with intellectual disability is well established. *See, e.g.*, Anton Dosen & Jan J. M. Gielen, *Depression in Persons with Mental Retardation: Assessment and Diagnosis*, in *Mental Health Aspects of Mental Retardation: Progress in Assessment and Treatment* 70 (Robert J. Fletcher & Anton Dosen eds., 1993); Sigan L. Hartley & William E. MacLean, Jr., *Depression in Adults with Mild Intellectual Disability: Role of Stress, Attributions, and Coping*, 114 Am. J. Intellectual & Developmental Disabilities 147 (2009); Lauren Charlot et al., *Mood Disorders*, in *Diagnostic Manual–Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability* 271–316 (Robert Fletcher et al. eds., 2007).

There is also abundant clinical evidence about the heightened vulnerability of some individuals with intellectual disability to post-traumatic stress disorder (PTSD). *See, e.g.*, Daniel J. Tomasulo & Nancy J. Razza, *Posttraumatic Stress Disorder*, in *Diagnostic Manual–Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability* 365, 368 (Robert Fletcher et al. eds., 2007) ("In addition to lower intellectual levels, people with ID [intellectual disabilities] have higher rates of many additional factors known to increase vulnerability to PTSD, such as early separation from parents (through early institutionalization or hospital admissions), lower educational levels, less training and preparation for negative life events (training and preparation that might have increased the individual's sense of personal control), and limited capacity for garnering social support.");

The fact that an individual who has intellectual disability also has another mental condition or mental illness does not alter the diagnostic process. In particular, co-morbidity does not preclude a clinical determination that the individual has deficits in adaptive behavior that satisfy the second prong of the definition.[26] There is

---

Ludwik S. Szymanski & Maija Wilska, *Childhood Disorders: Mental Retardation*, in 1 *Psychiatry* 687, 718 (Allan Tasman et al. eds., 2d ed. 2003); Ruth Ryan, *Posttraumatic Stress Disorder in Persons with Developmental Disabilities*, 30 Community Mental Health J. 45, 46 (1994) ("People with developmental disabilities are more likely than nondisabled persons to be abused physically, emotionally, or sexually."); Chrissoula Stavrakaki & Yona Lunsky, *Depression, Anxiety, and Adjustment Disorders in People with Intellectual Disabilities*, in *Psychiatric and Behavioural Disorders in Intellectual and Developmental Disabilities* 113, 119 (Nick Bouras & Geraldine Holt eds., 2d ed. 2007) ("One major cause of PTSD in these individuals are high rates of physical and sexual abuse.").

The phenomenon of dual diagnosis has also been noted by this Court. *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 593 (1999) ("Respondents L. C. and E. W. are mentally retarded women; L. C. has also been diagnosed with schizophrenia, and E. W. with a personality disorder."); *Brumfield v. Cain*, 135 S. Ct. 2269, 2280 (2015) ("[T]he diagnosis should be made . . . regardless of and in addition to the presence of another disorder." (quoting American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 47 (4th ed. text rev. 2000)), (citing American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 172 (10th ed. 2002)).

[26] Using the possible existence of a co-morbid mental illness in an individual to alter or preclude an otherwise-valid diagnosis of intellectual disability is incompatible with accepted clinical practice. *See, e.g.*, J. Gregory Olley, *The Death Penalty, the Courts, and Intellectual Disabilities*, in *The Handbook of*

High-Risk Challenging Behaviors in People with Intellectual and Developmental Disabilities 229, 232 (James K. Luiselli ed., 2012) ("An understanding of dual diagnoses is important because it may be mistakenly argued in court that the defendant has a mental illness diagnosis that rules out mental retardation.").

In this regard, it is important to note that the definition of intellectual disability does not contain a requirement that the deficits in adaptive behavior (Prong 2) be *caused by* the deficits in intellectual functioning (Prong 1). *See, e.g.*, AAIDD, *Manual 2010*, *supra* note 5, at 1 ("Intellectual disability is characterized by significant limitations both in intellectual functioning and in adaptive behavior . . . ."); *DSM-5*, *supra* note 5, at 33 ("Intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains."). Nor have earlier iterations of the definition contained a requirement of *causation* between the first and second prongs. *See, e.g.*, American Association on Mental Deficiency, *Manual on Terminology and Classification in Mental Retardation* 11 (rev. ed. 1973) ("Mental Retardation refers to significantly subaverage general intellectual functioning *existing concurrently* with deficits in adaptive behavior, and manifested during the developmental period." (emphasis added)).

Although no formulation of the definition has ever required proof that the intellectual impairment caused the deficits in adaptive functioning, some versions have used the term "related" in reference to the two prongs. *See DSM-5*, *supra* note 5, at 38 ("[T]he deficits in adaptive functioning must be directly related to the intellectual impairments . . . ."); American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 5 (9th ed. 1992) ("existing concurrently with related limitations in . . . adaptive skill areas . . . ."). But when it has been included, the term "related" has always required only a relatively minimal connection. *Id.* at 6 ("The limitations in adaptive skills are more closely related to the intellectual

no reason, nor do we have a methodology, to somehow "separate out" the effects of multiple conditions. Neither the accuracy nor the consistency of *Atkins* adjudications are enhanced by inviting witnesses — or triers of fact — to *guess* about the causation of a defendant's established deficits in adaptive behavior.

D. Clinical Judgment

Intellectual disability is a complex condition, and an accurate clinical diagnostic process cannot be limited to psychometric instruments alone. Evaluating an individual who may have intellectual disability involves more than technical details: the clinical experts must also be given latitude to exercise and explain the role of their professional

---

limitation than to some other circumstances such as cultural or linguistic diversity or sensory limitation.").

A central reason that the diagnostic criteria have never included a requirement of demonstrating causation is that clinicians have never possessed instruments or a scientifically based methodology for ascertaining whether the one phenomenon is caused by the other. As a result, there can be no scientific basis for a court (or a witness) to reach a diagnostic conclusion that a defendant's deficits in adaptive functioning were *caused by* the existence of a mental illness (rather than having been caused by the deficits in intellectual functioning). Such a conclusion is scientifically unsupported and unsupportable. Placing the burden of proof on an intellectually impaired individual to demonstrate that his adaptive deficits were caused by his intellectual impairment would require him to prove the unprovable.

judgment[27] in reaching their conclusions.[28] Under professional standards, diagnosticians are not free to replace the requirements of the clinical definition with their own impressionistic views.[29] It is essential that the clinician's judgment rests on an empirical and fully documented assessment.[30]

---

[27] Keith F. Widaman, *Concepts of Measurement*, in *The Death Penalty and Intellectual Disability* 55, 59 (Edward A. Polloway ed., 2015) ("[T]he need for clinical judgment to combine all information to arrive at important diagnostic decisions is always a component of this assessment task."); Robert L. Schalock & Ruth Luckasson, *Clinical Judgment* 7 (2d. ed. 2014) ("The purpose of clinical judgment is to enhance the quality, validity, and precision of the clinician's decision or recommendation in situations related to diagnosis, classification, and planning supports.").

[28] *See also* American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, *Standards for Educational and Psychological Testing* 164 (2014) ("Test score interpretation requires professionally responsible judgment that is exercised within the boundaries of knowledge and skill afforded by the professional's education, training, and supervised experience as well as the context in which the assessment is being performed."); *DSM-5*, *supra* note 5, at 37 ("Clinical training and judgment are required to interpret test results and assess intellectual performance.").

[29] *See* Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 121 (2009) ("Hence, clinical judgment should not be used as a shield when one draws conclusions that are not supported by the assessment results, observations, and/or case records.").

[30] This excludes, of course, impressionistic and unscientific "observations."

Diagnoses lack validity when basic scientific principles are ignored.[31]

> Alternatively, an examiner might simply conclude that the defendant "does not seem mentally retarded," independent of IQ score, effort testing, and structured adaptive behavior assessment. Such idiosyncratic methods and intuitive observations have no normative comparisons, have not been scientifically tested, have no known reliability or validity, and reflect unsystematic and potentially confirmatory sampling bias. Whatever their anecdotal appeal, such methods lack scientific rigor and are not appropriate expressions of clinical judgment.

Macvaugh & Cunningham, *supra* note 11, at 155.

[31] *See* American Psychological Association, *Specialty Guidelines for Forensic Psychology*, 68 Am. Psychologist 7, 15 (2013) ("Forensic practitioners use assessment procedures in the manner and for the purposes that are appropriate in light of the research on or evidence of their usefulness and proper application."); American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct*, 57 Am. Psychologist 1060, 1064 (2002) ("Psychologists' work is based upon established scientific and professional knowledge of the discipline.") (Standard 2.04); *see also* Robert L. Schalock & Ruth Luckasson, *Clinical Judgment* 15 (2d ed. 2014) ("Clinical judgment is *not* . . . a vehicle for stereotypes or prejudices . . . .").

II. States Are Not Free to Ignore Accepted Scientific Standards in Adjudicating Cases Involving Intellectual Disability.

The scientific and clinical understanding of intellectual disability is no less essential for the adaptive behavior prong than it is for the intellectual impairment prong. *See Hall v. Florida*, 134 S. Ct. 1986, 2001 (2014) (The defendant must "have the opportunity to present evidence of his intellectual disability, including deficits in adaptive functioning over his lifetime."). And the scientific consensus about the proper diagnostic standards regarding deficits is as clear and as firmly established as the consensus about measuring intellectual functioning.

As is the case in other fields, clinical science advances with new discoveries and, more frequently, with refined understanding of established principles. Our clinical understanding of intellectual disability is no exception. In implementing this Court's ruling in *Atkins*, lower courts must be free to consider refinements of our understanding of the phenomenon, and cannot be commanded to blind themselves to the advancements in the consensus of scientists and clinicians. Clinical understanding cannot, of course, be treated as if it were fixed in amber, and any requirement for courts to willfully blind their eyes to proven advances in scientific understanding is inconsistent with basic Constitutional principles.[32]

---

[32] *See generally Graham v. Florida*, 560 U.S. 48, 68 (2010) ("[D]evelopments in psychology and brain science continue to show fundamental differences between juvenile and adult minds."); *Miller v. Alabama*, 132 S. Ct. 2455, 2464 n.5 (2012)

But the larger constitutional issue presented by this case is the choice by the Texas Court of Criminal Appeals to ignore scientific principles altogether, even those that have been clearly accepted and established for decades.[33] The court maintains that the Eighth Amendment protections of *Atkins* apply only to a sub-set of defendants with intellectual disability,[34] and therefore it need not use clinical standards.[35]

("The evidence presented to us in these cases indicates that the science and social science supporting *Roper*'s and *Graham*'s conclusions have become even stronger.").

[33] As this Court noted in *Hall*, "[T]he legal determination of intellectual disability is distinct from a medical diagnosis, but it is informed by the medical community's diagnostic framework." 134 S. Ct. 1986, 2000 (2014). Since the Texas approach to the second prong is supported by virtually *no* clinical authority, it can hardly be seen as "informed by the medical community's diagnostic framework."

[34] Remarkably, the Court of Criminal Appeals offers, as part of its justification for the consideration for nonclinical factors, the suggestion that this Court's finding of a national consensus against executing individuals with intellectual disability might not be controlling. It speculates about whether "[there is] a national *or Texas consensus* that all of those persons whom the mental health profession might diagnose as meeting the criteria for mental retardation are automatically less morally culpable than those who just barely miss meeting those criteria?" *Ex parte Briseno*, 135 S.W.3d 1, 6 (Tex. Crim. App. 2004) (emphasis added). It also suggests that this narrower protected group who satisfy the Texas consensus may be defined by their "level and degree of mental retardation." *Id.* While this Court invited the States to devise procedures for the adjudication of intellectual disability cases, *Atkins v. Virginia*, 536 U.S. 304, 317 (2002), it has never suggested that any State is authorized to reduce the group of individuals entitled to Eighth Amendment protection because of a perceived consensus

As an additional part of its effort to limit the reach of *Atkins*, Texas instructs its courts to evaluate defendants using a list of characteristics that it deems incompatible with a diagnosis of intellectual disability. *See Ex parte Briseno*, 135 S.W.3d 1, 8–9 (Tex. Crim. App. 2004). The list of so-called "factors" consists primarily of stereotypes and supposed

---

in that State. *See Hall*, 134 S. Ct. at 1999 ("If the States were to have complete autonomy to define intellectual disability as they wished, the Court's decision in *Atkins* could become a nullity, and the Eighth Amendment's protection of human dignity would not become reality.").

35 In the opinion below, the Texas Court of Criminal Appeals rejected the clinical standard for the diagnosis of intellectual disability for *Atkins* purposes. It explained that, in its view, there are two different definitions of adaptive behavior, one "[f]or purposes of the Eighth Amendment," and the other from clinical organizations "for purposes of making a clinical diagnosis of intellectual disability." *Ex parte Moore*, 470 S.W.3d 481, 488 (Tex. Crim. App. 2015). The court elaborated on its differing standards theory stating that "[i]n the Eighth Amendment context," applicants must satisfy more than the first two prongs of the clinical definition, they must also prove *causation* between them by showing that "adaptive behavior deficits are related to significantly sub-average general intellectual functioning rather than some other cause." *Id.* (The "other" causes about which the court speculated in this case included childhood abuse-related trauma and learning disability.) *Id.* at 526. Finally, the court stated that it had chosen to disregard the testimony of the defendant's experts because they "appear to have applied a more demanding standard to the issue of adaptive behavior than we have contemplated for Eighth Amendment purposes." *Id.* at 525. Specifically it took issue with the fact that the experts had complied with accepted clinical standards by refusing to consider stereotypes, isolated strengths, and testimony about prison behavior in their assessment. *See id.*

strengths, such as planning ability, responding rationally, and dissembling.[36] This approach violates the established diagnostic principle that the second prong of the definition focuses solely on *deficits* rather than isolated strengths or abilities.

Distorting the definition with invented exclusionary factors is fundamentally inconsistent with the clinical understanding of intellectual disability, and has no support in the scientific and clinical literature in the field.[37] It has been rejected by scholars and practitioners who study and work

---

[36] The Court of Criminal Appeals maintains that the *Briseno* factors do not replace the clinical definition, but rather merely supplement or augment it. *See, e.g.*, *Ex parte Sosa*, 364 S.W.3d 889, 892 (Tex. Crim. App. 2012) ("While we did not make consideration of any or all of these factors mandatory, they reflected our concern that the AAIDD's guidelines should not be considered in isolation, but rather in the context of the concerns expressed by the Supreme Court in *Atkins*."). The Texas court's expressed concern is that the clinical definition of the second prong is too "subjective," and that its invented factors are "more objective." *See Ex parte Cathey*, 451 S.W.3d 1, 11 n.22 (Tex. Crim. App. 2014). However, there appear to be no cases in which the court uses its factors to expand the group of individuals who satisfy the second prong, but abundant examples where they are used to restrict it to a sub-set of those who satisfy the clinical definition. It has instructed lower courts by reversing at least one decision that used the clinical definition, and ordered reconsideration in light of the factors. *Sosa*, 364 S.W.3d at 890.

[37] Notably, Texas uses the clinical definition of intellectual disability for all legal purposes other than those involving the death penalty. *See, e.g.*, Tex. Health & Safety Code Ann. § 593.005 (West 2010 & Supp. 2016).

with people with intellectual disability.[38] Each of the Texas court's factors is individually problematic because none is based upon clinical understanding of intellectual disability.[39] However, the more

---

[38] *See, e.g.*, Macvaugh & Cunningham, *supra* note 11, at 136 ("The seven criteria of the *Briseno* opinion operationalize an *Atkins* interpretation that only exempts a subcategory of persons with mental retardation from execution."); Caroline Everington, *Challenges of Conveying Intellectual Disabilities to Judge and Jury*, 23 Wm. & Mary Bill Rts. J. 467, 481 (2014) ("Using these seven factors as part of a diagnosis has the potential (if strictly interpreted) to exclude anyone functioning in the mild ID range from the protection of *Atkins*.").

Dr. Everington's concern about the exclusion from *Atkins* protection of individuals with "mild" ID (who constitute the vast majority of capital defendants with intellectual disability) seems fully borne out by the Court of Criminal Appeals' observation about whether the *Briseno* factors align with the clinical definition. *See, e.g.*, *Sosa*, 364 S.W.3d at 892.

[39] The almost exclusive focus of the Texas factors is on purported strengths or abilities of the individual, rather than deficits. In addition, the first factor, whether others viewed the individual as having mental retardation, *see Briseno*, 135 S.W.3d at 8, relies on whatever stereotypes that particular lay informant may have held about what "mental retardation" meant and looked like. But the Texas factor that is most obviously at odds with the clinical literature concerning the diagnosis of intellectual disability is the final one in the list: whether the facts of the crime were consistent with a diagnosis of mental retardation. In addition to their potentially prejudicial effect, *see generally* Fed. R. Evid. 403, the facts of the crime have no relevance to deficits, and this approach has been rejected by clinical experts. *See, e.g.*, Macvaugh & Cunningham, *supra* note 11, at 169 ("Evaluators are discouraged from utilizing criminal behavior to ascertain the presence or absence of deficits in adaptive functioning."); American Association on Intellectual and Developmental Disabilities, *User's Guide: Intellectual Disability: Definition,*

fundamental problem is that both the apparent goal, and the actual effect, of reducing the number of defendants entitled to the Constitution's protection are inconsistent with this Court's teachings.

The Texas re-formulation of the definition's second prong bears little resemblance to the professional definition's clear focus on deficits in adaptive behavior. This approach is inconsistent with accepted diagnostic standards and practices.

As this Court has observed, "Not all people who claim to be mentally retarded will be so impaired as to fall within the range of mentally retarded offenders about whom there is a national consensus." *Atkins v. Virginia*, 536 U.S. 304, 317 (2002). But every capital defendant who may have intellectual disability should have the relevant evidence evaluated according to scientifically accepted standards.

Texas' invention and adoption of a list of unscientific criteria for adaptive functioning has the

---

Classification, and Systems of Supports 18 (2012) ("Distinguish between adaptive behavior and problem behavior(s). They are independent constructs and not opposite poles of a continuum. Information regarding problem behavior does not inform the clinician regarding the person's adaptive behavior."); *id.* at 20 ("Do not use past criminal behavior or verbal behavior to infer level of adaptive behavior. . . . The diagnosis of ID is not based on the person's 'street smarts', behavior in jail or prison, or 'criminal adaptive functioning.'").

effect (and, apparently, the purpose) of limiting the protection of *Atkins* to a sub-set of those defendants who satisfy the clinical definition of intellectual disability.[40] This is incompatible with the Eighth Amendment's prohibition of Cruel and Unusual Punishments.

Amici believe that the basic framework of the clinical definition is the constitutionally required standard for determining whether a defendant has intellectual disability.

CONCLUSION

For the foregoing reasons, *amici* urge this Court to reverse the judgment of the Texas Court of Criminal Appeals.

Respectfully submitted,

JAMES W. ELLIS
Counsel of Record
ANN M. DELPHA
CAROL M. SUZUKI
STEVEN K. HOMER
DAVID J. STOUT
APRIL LAND

August 4, 2016 *Counsel for Amici Curiae*

---

[40] *See Roper v. Simmons*, 543 U.S. 551, 563–64 (2005) (In *Atkins*, "the Court ruled that the death penalty constitutes an excessive sanction for the entire category of mentally retarded offenders.").